WEST VIRGINIA BOARD OF EXAMINERS FOR REGISTERED PROFESSIONAL NURSES
101 DEE DRIVE, CHARLESTON, WV 25311-1620
TELEPHONE (304) 558-3596 or 1-877-743-NURS(6877)FAX (304) 558-3666
www.wvrnboard.comemail: rnboard@wv.gov

REINSTATEMENT APPLICATION FOR PRESCRIPTIVE WRITING PRIVILEGES

The Prescriptive Authority Privilege is on a two (2) year cycle. ALL CURRENT Prescriptive Authority Privileges expire June 30, 2015.

_____

Last First Middle Maiden

(Name changes require submission of a notarized affidavit or notarized copy of the legal documents validating the change and an additional $5.00 fee. Address changes must be submitted in writing to the Board within 30 days of the address change. There is no fee for address changes.)

Social Security Number _____-_____-_____ **WV RN License #** _____

WV Prescriptive Authority Number_____ **Do you have DEA registration? Yes (If yes, attach a copy of certificate) No**

1. Have you ever had disciplinary action taken against your license, or is action pending in any other state?

Yes (If yes, attach an explanation) No

2. Has your nursing practice ever been disciplined or monitored for any reason, icluding monetary fines, continuing education, etc., by any facility, board or group?

Yes (If yes, attach an explanation) No

3. Have you ever been convicted of a felony or a misdemeanor or pled nolo contendere to any crime?
Minor traffic violations such as speeding or parking tickets do not have to be reported.

Yes (If yes, attach a certified copy of all No

court documents and an explanation)

4. Have you ever or are you currently abusing prescription or over-the-counter medication?

Yes (If yes, attach an explanation) No

5. Do you currently possess any condition which may in any way impair your ability to practice or otherwise alter your behavior as it relates to the practice of registered professional nursing?

Yes (If yes, attach an explanation) No

6. Is there any reason why your access to narcotics or substances of abuse should be restricted or limited?

Yes (if yes, attach an explanation) No

CERTIFICATION TYPE (Attach copy of the Certification card) **NUMBER** **EXP DATE**

_____ _____ _____

CONTINUING EDUCATION

Attach a copy of the certificate(s) showing completion of eight (8) hours of continuing education in Pharmacology approved by the Board and obtained after June 30, 2011 and not used for any other application.

FEE OF $125.00 to be submitted with the application.

Fee is non-refundable. Personal checks may be submitted. Make the fee payable to the West Virginia Board of Registered Nurses.

Place your license number on your check for easy reference.

COPY OF COLLABORATIVE AGREEMENT(s)

A notarized copy of your collaborative agreement(s) is to be submitted with this application. You may duplicate the verification portion of this application if you have more than one (1) collaborative agreement.

VERIFICATION OF A COLLABORATIVE AGREEMENT FOR

PRESCRIPTIVE WRITING PRIVILEGES

(Complete for each collaborative physician)

I_____(license number_____/RXA number_____) certify by my signature that a written collaborative agreement exists between myself and Dr. _____(license number_____), and that written guideline/protocols for prescriptive practice are signed and in place. My collaborative agreement with Dr. _____ begins on _____, expires on _____ (cannot exceed expiration date of 06/30/2015) and expires with termination of my employment. Both myself and the above named physician have read and understand the regulations pertaining to prescriptive writing privileges (Federal and State prescribing laws including West Virginia Code for Registered Professional Nurses §30-7-15a,b,c; §30-15-7a,b,c for midwives; and

West Virginia Legislative Rule §19CSR8). I understand that for prescriptive writing privileges, the collaborative agreement includes, but is not limited to, the following:

(Please check to indicate completion)

- ☐ Mutually agreed upon written guidelines or protocols for prescriptive authority as it applies to the advance nurse practitioner's prescriptive practice. I have listed below protocols the guidelines and protocols used in my practice.

_____

_____

_____

_____

_____

- ☐ Statements describing the individual and shared responsibilities of the advanced nurse practitioner and the physician pursuant to the collaborative agreement between them are listed below:

_____

_____

_____

_____

_____

□ Periodic and joint evaluation of prescriptive practice will occur as listed below:

Frequency of record review_____ Number of records reviewed____; and

□ Periodic and joint review and updating of the written guidelines or protocols will occur _____(frequency).

Prescriptive Authority Verification

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I further understand that I must assure that current information regarding collaborative agreements is **on file at the Board office**. I understand that I must have at least one current collaborative agreement verification on file at the Board office at all times. When my collaborative agreement is no longer valid (i.e. dissolvement of agreement, agreement not renewed, termination of my employment), I understand that I am to notify the Board office immediately. I further understand that my prescribing privileges are for practice only in the state of West Virginia and that my prescribing practice may be audited/reviewed by the Board. I will practice according to Federal and State Law, the standards of practice in my specialty area, my education and documented competence.

Furthermore, I, the undersigned, being duly sworn, according to law, do depose and say that I am the person making this application; that the statements therein are true to the best of my knowledge and belief; that I have read and understand the Law and Rule pertaining to prescriptive authority; I understand that failure to comply with requirements for licensure, and that knowingly supplying false information on or with this verification is a violation of WV Code §30-7-1 et.seq. and subjects me to the full range of disciplinary action described therein.

Name of Applicant: _____

Practice Address: _____

_____

Phone: _____Fax:_____Email:_____

Name of Physician: _____

Practice Address: _____

_____

Phone: _____Fax:_____Email:_____

Applicant's Signature_____Date:_____

Physician's Signature_____Date:_____

SUBSCRIBED AND SWORN TO BEFORE ME this ____ day of _____, 20__

My commission expires _____

_____

(SEAL) Notary Public

Revised 11.21.2013